DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-309 (Rev.7-03)

STATE OF WISCONSIN

FOR OFFICE USE
☐ approved ☐ denied ☐ approved w/conditions
SIGNATURE – RFOS
Date

SELF SUPERVISION EVALUATION AND WAIVER REQUEST

The purpose of this evaluation is to determine if a resident is functioning sufficiently independent of supervision and assistance by staff and could benefit from having opportunities to remain in a CBRF, unsupervised for specified and limited periods of time. This evaluation is designed to provide a structured means of planning for a resident's movement toward greater independent functioning.

Submission of this completed evaluation constitutes a request for a waiver of the staff coverage requirements specified in Wisconsin Administrative Code, HFS 83.15(1)(c), which states, "At least one qualified resident care staff member shall be present in the facility when one or more residents are in the facility." This waiver request must be in the best interest of the resident's development of skills for more independent functioning and not to accommodate staffing schedules.

This evaluation is to be completed by the staff person(s) most familiar with the resident's functioning. It must be completed with the direct participation of the resident. Completion of this form is voluntary.

Name- Resident	Resident Classification	Date Submitted
Name – Facility		Facility Classification
Facility Address		
City	Zip Code	Telephone Number

1. At the time of application for this waiver, how many other current residents in this facility have been granted a waiver for self-supervision?

2. Has a request for this resident been made previously? ☐ Yes ☐ No
   If YES, please explain:

3. How many residents do you currently have in your facility?

Except for the questions which ask for a YES or NO response or a written response, all of the questions in Sections I, II and III must be answered using one of the following three responses which most accurately describe the resident's ability for each question. Please write the corresponding number for the appropriate response in the space to the left of each question.

(1) Does NOT do (2) Does with assistance or prompting (3) Does independently

	I. HOME SAFETY AND PERSONAL CARE
	a. Knows his/her name, address and phone number
	b. Uses the telephone
	c. Carries and uses identification appropriately
	d. Independently structures leisure time activities
	e. Adheres to house rules
	f. Maintains a secure home: -locks doors -keeps strangers out -carries own door key
	g. Communicates his/her needs
	h. Controls own emotions and behavior
	i. Follows directions

	j. Has appropriate mobility skills and safety measures in traveling about the neighborhood or community
	k. Has ability to provide slef-care for minor injuries such as cuts, scrapes, sprains, etc.

II. FIRE SAFETY

	a. Recognizes the potential for hazards such as careless use of smoking materials, loose fitting clothes catching on fire when cooking, improper use of combustible liquids.
	b. Properly evacuates building without assistance when a fire alarm is sounded Indicate the amount of time it takes this person to evacuate the building during a fire drill
	c. Can call fire department NOTE: The fire department number must be attached to a fixed object near the phone.
	d. Knows how and where to contact the facility manager, staff or other designee when all staff are away from the facility. **EXPLAIN** what you have done to ensure that this resident is able to contact someone for help in an emergency.

III. MEDICATIONS

Yes	No	
☐	☐	a. Is this person currently receiving prescribed medications? If "**YES**" please respond to questions "b" through "j". If "**NO**" please respond to questions "i" through "j"
		b. List current medications including dosages and times of administration:
☐	☐	c. Would medication during self-supervision periods be necessary? If "**NO**", please go to questions "I" and "j".
☐	☐	d. Does the person: Control his/her medication container(s)
☐	☐	Have the facility control the medication container(s)
☐	☐	e. Recognizes his or her medication containers
☐	☐	f. Knows proper amount of medication
☐	☐	g. Knows proper time(s) to take medication
☐	☐	h. Takes own medication without supervision
☐	☐	i. Is the person subject to seizure activity?
		If "**YES**", explain frequency, duration, effect of current control, potential dangers, etc.

j. List any special recommendations or restrictions made by the individual's physician.

Name - Physician

IV. GENERAL INFORMATION REGARDING SELF-SUPERVISION

a. What areas of specific functioning will be improved for this person through self-supervision.
EXPLAIN:

b. Are these goals consistent with the resident's individualized service plan as required in HFS 83.32 (2 and 3)?
☐ Yes ☐ No

c. Does the person want or need to be left unsupervised? ☐ Yes ☐ No
EXPLAIN:

d. What activities (entertainment, house responsibilities, leisure time activities in the community, etc.) would the person engage in while unsupervised?

e. What evidence has the person given, in the past, of being responsible enough to be in the house unsupervised? Include examples of unsupervised times at work or travel.

f. Are this resident's behavior characteristics compatible with those of other residents being considered for, or already on, self supervision?
EXPLAIN:

V. RESTRICTIONS

a. Please identify the times during each day that the person would be on self-supervision

DAY OF WEEK	TIMES REQUESTED (for example 2PM – 4PM on Tuesdays, 10AM – 11AM Sundays)
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

b. What is the maximum continuous period of time that this resident would be left unsupervised?

c. List any limits to this person's activities when on self-supervision. Examples are: no smoking, no cooking, no alcoholic beverages, etc.

SIGNATURES

Resident

I (the resident) am aware of my responsibilities and the privileges extended to me by this evaluation. I understand and agree to all of the listed restrictions placed upon me during the period of unsupervised time in the home as well as all other current house rules. I also understand and agree that any violation of these restrictions, prior to a re-evaluation, automatically terminates my ability to remain in the home unsupervised until such time as a new evaluation is initiated.

SIGNATURE - Resident	Date Signed
SIGNATURE – County Case Worker Completing This Form	Date Signed
SIGNATURE - Person(s) Completing This Form	Date Signed

Legal Guardian

I acknowledge that this evaluation in no way relieves me of my responsibilities or rights as a guardian for

_____. I do agree that the evaluation, as presented, is in keeping with his or her right to training for greater independence and self-responsibility.

SIGNATURE – Guardian	Date Signed

Licensee

I (the licensee) agree with the evaluation as being a true and accurate description of the resident's functioning, and with the restrictions placed upon the resident during his/her unsupervised time in the home. I understand that the approval of this waiver request by the Division of Disability and Elder Services does not relieve me of my responsibility for the health, safety and welfare of the resident identified in this evaluation while he / she is on self-supervision.

SIGNATURE – Licensee	Date Signed
SIGNATURE – Administrator (if different from licensee)	Date Signed